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morpace Market Research & Consulting

2016 CAHPS® Adult Medicaid Survey Executive Summary

Oklahoma Health Care Authority

June 2016

Oklahoma HealthCare Authority

Morpace research is completed in compliance with ISO 20252

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Background and Protocol

Background

- CAHPS® measures health care consumers' satisfaction with the quality of care and customer service provided by their health plan. Plans which are collecting HEDIS® (Healthcare Effectiveness Data and Information Set) data for NCQA accreditation are required to field the CAHPS® survey among their eligible populations.

Protocol

- For CAHPS® results to be considered in HEDIS® results, the CAHPS® 5.0H survey must be fielded by an NCQA (National Committee for Quality Assurance)-certified survey vendor using an NCQA-approved protocol of administration in order to ensure that results are collected in a standardized way and can be compared across plans. Standard NCQA protocols for administering CAHPS® 5.0H include a mixed-mode mail/telephone protocol and a mail-only protocol.

- The protocol includes the following:

Pre-notification postcard mailed (optional)

Questionnaire with cover letter and business reply envelope (BRE) mailed

Internet link included on cover letter (optional)

1st reminder postcard mailed

Replacement questionnaire with cover letter and BRE to all non-responders

Internet link included on cover letter (optional)

2nd reminder postcard mailed

Telephone interviews conducted with non-responders (min of 3/max of 6 attempts)

- Oklahoma Health Care Authority chose the mail/telephone/Internet protocol.

Executive Summary

Sample

- NCQA originally designed this protocol with the goal of achieving a total response rate of at least 45%. In 2015, the average response rate for all Adult Medicaid plans reporting to NCQA was 27%, which is lower than the 2014 average (29%).
- In February, 1823 Oklahoma Health Care Authority members were randomly selected to participate in the 2016 CAHPS® 5.0H Adult Medicaid Survey. The survey results presented in this report are compiled from the 474 Oklahoma Health Care Authority members who responded to the survey.

	Sample Size	Total Completes	English Completes	Spanish Completes
Oklahoma Health Care Authority	1823	474	471	3

Executive Summary

Disposition Summary and Response Rate

- A response rate is calculated for those members who were eligible and able to respond.
- A completed questionnaire is defined as a respondent who completed three of the five required questions that all respondents are eligible to answer (question #3,15, 24, 28, 35).
- According to NCQA protocol, ineligible members include those who are deceased, do not meet eligible criteria, have a language barrier, are either mentally physically incapacitated, or duplicate household to another member selected in the sample.
- Non-responders include those members who refuse to participate in the current year's survey, could not be reached due to a bad address or telephone number, members that reached a maximum attempt threshold without a response, or members that did not meet the completed survey definition.
- The table below shows the total number of members in the sample that fell into each of the various disposition categories.

Oklahoma Health Care Authority
2016 Disposition Summary

Ineligible	Number
Deceased (M20/T20)	16
Does not meet criteria (M21/T21/I21)	14
Language barrier (M22/T22)	4
Mentally/physically incapacitated (M24/T24)	21
Sample duplicates (ID1/ID2)	0
Total Ineligible	**55**

Non-response	Number
Bad address/phone (M23/T23)	155
Partial complete (M31/T31/I31)	16
Refusal (M32/T32)	62
Maximum attempts made (M33/T33)	1061
Total Non-response	**1294**

- Ineligible surveys are subtracted from the sample size when computing a response rate (see below):

$$\frac{\textit{Completed mail, telephone and Internet surveys}}{\textit{Sample size - Ineligible surveys}} = \textit{Response Rate}$$

- Using the final figures from Oklahoma Health Care Authority's Adult Medicaid survey, the 2016 response rate is calculated using the equation below:

$$\frac{\textit{Mail completes (344) + Phone completes (112) + Internet completes (18)}}{\textit{Total Sample (1823) - Total Ineligible (55)}} = \frac{474}{1768} = \textit{Response Rate} = \mathbf{27\%}$$

Executive Summary
Summary of Key Measures

- For purposes of reporting the CAHPS® results in HEDIS® (Healthcare Effectiveness Data and Information Set) and for scoring for health plan accreditation, the National Committee for Quality Assurance (NCQA) uses 5 composite measures and 4 rating questions from the survey.
- Each of the composite measures is the average of 2 - 4 questions on the survey, depending on the measure, while each rating score is based on a single question. CAHPS® scores are most commonly shown using Summary Rate scores (percentage of positive responses).

Oklahoma Health Care Authority				
	Trended Data			
Composite Measures	**2013**	**2014**	**2015**	**2016**
Getting Care Quickly	79%	82%	86%	84%
Shared Decision Making	NT	NT	77%	77%
How Well Doctors Communicate	87%	90%	90%	91%
Getting Needed Care	80%	82%	85%	85%
Customer Service	90%	82%	92%	87%
Overall Rating Measures				
Health Care	64%	68%	72%	74%
Personal Doctor	71%	79%↑	80%	81%
Specialist	75%	83%	78%	83%
Health Plan	61%	73%↑	73%	67%
HEDIS® Measures				
Flu Vaccinations***	NA	45%	46%	43%
Advising Smokers and Tobacco Users to Quit*	76%	75%	74%	76%
Discussing Cessation Medications*	45%	48%	49%	50%
Discussing Cessation Strategies*	42%	44%	46%	48%
Aspirin Use**	NR	NR	NR	NR
Discussing Aspirin Risks and Benefits**	NR	NR	NR	NR
Health Promotion & Education	70%	71%	71%	70%
Coordination of Care	77%	83%	79%	79%
Sample Size	*1350*	*1350*	*1823*	*1823*
# of Completes	*414*	*309*	*426*	*474*
Response Rate	*32%*	*23%*	*24%*	*27%*

Legend: ↑/↓ Statistically higher/lower compared to prior year results.
NA=Data not available NT=Data not trendable NR=Data not reportable

*Measure is reported using a Rolling Average Methodology. The score shown is the reportable score for the corresponding year.
**Measure is reported using a Rolling Average Methodology and is not reportable in 2016.
***Question text and age range changed in 2014. This is a single year measure.

Executive Summary

Scoring for NCQA Accreditation (Includes How Well Doctors Communicate)

				2016 NCQA National Accreditation Comparisons*				
				Below 25th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l
			Accreditation Points	***0.29***	***0.58***	***0.98***	***1.27***	***1.44***
Composite Scores	**Sample Size**	**Mean**	**Approximate Percentile Threshold**					***Approximate Score***
Getting Care Quickly	(n=305)	**2.458**	50th		2.36	2.42	2.46	2.49	***0.98***
How Well Doctors Communicate	(n=357)	**2.634**	75th		2.48	2.54	2.58	2.64	***1.27***
Getting Needed Care	(n=312)	**2.391**	50th		2.31	2.37	2.42	2.45	***0.98***
Customer Service	(n=106)	**2.509**	25th		2.48	2.54	2.58	2.61	***0.58***
Overall Ratings Scores									
Q13 Health Care	(n=383)	**2.366**	50th		2.31	2.36	2.42	2.45	***0.98***
Q23 Personal Doctor	(n=407)	**2.548**	75th		2.43	2.50	2.53	2.57	***1.27***
Q27 Specialist	(n=225)	**2.573**	75th		2.48	2.51	2.56	2.59	***1.27***
			Accreditation Points	***0.58***	***1.16***	***1.96***	***2.54***	***2.89***	
Q35 Health Plan	(n=458)	**2.293**	Below 25th		2.37	2.43	2.49	2.55	***0.58***
								Estimated Overall CAHPS® Score:	**7.91**

NOTE: NCQA begins their calculation with an unadjusted raw score showing six digits after the decimal and then compares the adjusted score to their benchmarks and thresholds (also calculated to the sixth decimal place). Starting in 2015, NCQA will no longer use an adjusted score. This report displays accreditation points and scores with only two digits after the decimal. Therefore, the estimated overall CAHPS® score may differ from the sum of the individual scores due to rounding and could differ slightly from official scores provided by NCQA. The CAHPS® measures account for 13 points towards accreditation.

*Data Source: **NCQA Memorandum of January 21, 2016.** Subject: 2016 Accreditation Benchmarks and Thresholds.

*** Not reportable due to insufficient sample size.

Executive Summary

Scoring for NCQA Accreditation (Includes Care Coordination)

				2016 NCQA National Accreditation Comparisons*				
				Below 25th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l
			Accreditation Points	***0.29***	***0.58***	***0.98***	***1.27***	***1.44***
Composite Scores	**Sample Size**	**Mean**	**Approximate Percentile Threshold**					***Approximate Score***
Getting Care Quickly	(n=305)	**2.458**	50th		2.36	2.42	2.46	2.49	***0.98***
Getting Needed Care	(n=312)	**2.391**	50th		2.31	2.37	2.42	2.45	***0.98***
Customer Service	(n=106)	**2.509**	25th		2.48	2.54	2.58	2.61	***0.58***
Care Coordination	(n=221)	**2.321**	Below 25th		2.33	2.39	2.43	2.49	***0.29***
Overall Ratings Scores									
Q13 Health Care	(n=383)	**2.366**	50th		2.31	2.36	2.42	2.45	***0.98***
Q23 Personal Doctor	(n=407)	**2.548**	75th		2.43	2.50	2.53	2.57	***1.27***
Q27 Specialist	(n=225)	**2.573**	75th		2.48	2.51	2.56	2.59	***1.27***
			Accreditation Points	***0.58***	***1.16***	***1.96***	***2.54***	***2.89***	
Q35 Health Plan	(n=458)	**2.293**	Below 25th		2.37	2.43	2.49	2.55	***0.58***
							Estimated Overall CAHPS® Score:		**6.93**

NOTE: NCQA begins their calculation with an unadjusted raw score showing six digits after the decimal and then compares the adjusted score to their benchmarks and thresholds (also calculated to the sixth decimal place). Starting in 2015, NCQA will no longer use an adjusted score. This report displays accreditation points and scores with only two digits after the decimal. Therefore, the estimated overall CAHPS® score may differ from the sum of the individual scores due to rounding and could differ slightly from official scores provided by NCQA. The CAHPS® measures account for 13 points towards accreditation.

*Data Source: **NCQA Memorandum of January 21, 2016.** Subject: 2016 Accreditation Benchmarks and Thresholds.

*** Not reportable due to insufficient sample size.

Executive Summary
Comparison to Quality Compass®

	Oklahoma Health Care Authority	2015 Adult Medicaid Quality Compass® Comparisons*						
		5th Nat'l	10th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l	95th Nat'l
Composite Scores		%	%	%	%	%	%	%
Getting Care Quickly *(% Always/Usually)*	**84.22%**	**72.32**	**73.99**	**78.73**	**81.55**	**83.48**	**85.26**	**86.61**
Shared Decision Making *(% Yes)*	**76.64%**	**74.21**	**74.93**	**76.65**	**78.56**	**80.41**	**82.28**	**83.94**
How Well Doctors Communicate *(% Always/Usually)*	**90.82%**	**86.99**	**88.13**	**89.21**	**90.70**	**92.17**	**93.29**	**94.23**
Getting Needed Care *(% Always/Usually)*	**84.53%**	**72.97**	**74.95**	**77.94**	**81.35**	**84.18**	**85.41**	**86.46**
Customer Service *(% Always/Usually)*	**87.22%**	**82.77**	**83.25**	**85.32**	**87.34**	**88.70**	**90.56**	**91.67**
Overall Ratings Scores								
Q13 Rating of Health Care (% 8, 9, 10)	**73.89%**	**63.55**	**66.67**	**70.15**	**72.82**	**75.50**	**77.68**	**79.00**
Q23 Rating of Personal Doctor (% 8, 9, 10)	**81.33%**	**73.07**	**75.00**	**77.69**	**80.00**	**82.06**	**84.17**	**86.28**
Q27 Rating of Specialist (% 8, 9, 10)	**83.11%**	**73.95**	**75.14**	**78.05**	**80.67**	**82.82**	**85.34**	**86.19**
Q35 Rating of Health Plan (% 8, 9, 10)	**67.25%**	**65.23**	**67.85**	**72.44**	**76.15**	**78.65**	**81.16**	**83.25**

*Data Source: 2015 Adult Medicaid Quality Compass®. Scores above based on 155 public and non-public reporting health plan products (All Lines of Business excluding PPOs).

= Plan score falls below 5th Percentile

Executive Summary

Action Plan – Rating of Health Plan

A Key Driver Analysis is conducted to understand the impact that different aspects of plan service and provider care have on members' overall satisfaction with their health plan, their personal doctor, their specialist, and health care in general. Two specific scores are assessed both individually and in relation to each other. These are:

1. The relative importance of the individual issues (Correlation to overall measures)
2. The current levels of performance on each issue (Percentile group in Quality Compass®)

Items that are a High Priority for Improvement are those measures that are highly correlated to the overall measure, and the plan's scores are below the 50th percentile of Quality Compass®. Below is a list of items that are considered a High Priority for Improvement to the Overall Rating of Health Plan as well as the Primary Recommendation for improving this measure. For more ideas on how to improve your scores, please see the *Action Plans for Improving CAHPS® Scores* section of this report.

High Priority for Improvement
(High correlation/Relatively low performance)

Overall Rating of Health Plan	Primary Recommendation
Q32 - Treated You with Courtesy and Respect	Operationally define customer service behaviors for Call Center representatives as well as all staff throughout the organization. Train staff on these behaviors.
Q19 - Show Respect for What You Had to Say	Conduct focus group of members to identify examples of behaviors identified in the questions. Video the groups to show physicians how patients characterize excellent and poor physician performance.
Q14 - Easy to Get Care Believed Necessary	Evaluate pre-certification, authorization, and appeals processes. Of even more importance is to evaluate the manner in which the decisions are communicated to the member. Members may be told that the health plan has not approved specific care, tests, or treatment, but are not being told why. The health plan should go the extra step to ensure that the member understands the decision and hears directly from them.
Q18 - Listen Carefully to You	Provide the physicians with patient education materials. These materials could reinforce that the physician has heard the concerns of the patient and/or that they are interested in the well-being of the patient. The materials might also speak to a healthy habit that the physician wants the patient to adopt, thereby reinforcing the communication and increasing the chances for compliance. Materials should be available in appropriate/relevant languages and reading levels for the population.

Executive Summary

Key Driver Analysis – Health Plan

Use caution when reviewing scores with sample sizes less than 25.

"Health Plan's Score" is the percent of respondents that answered “Always”, “Usually”; “Yes”

High Priority for Improvement
(High Correlation/
Lower Quality Compass® Group)

Q32 - Treated You with Courtesy and Respect
Q19 - Show Respect for What You Had to Say
Q14 - Easy to Get Care Believed Necessary
Q18 - Listen Carefully to You

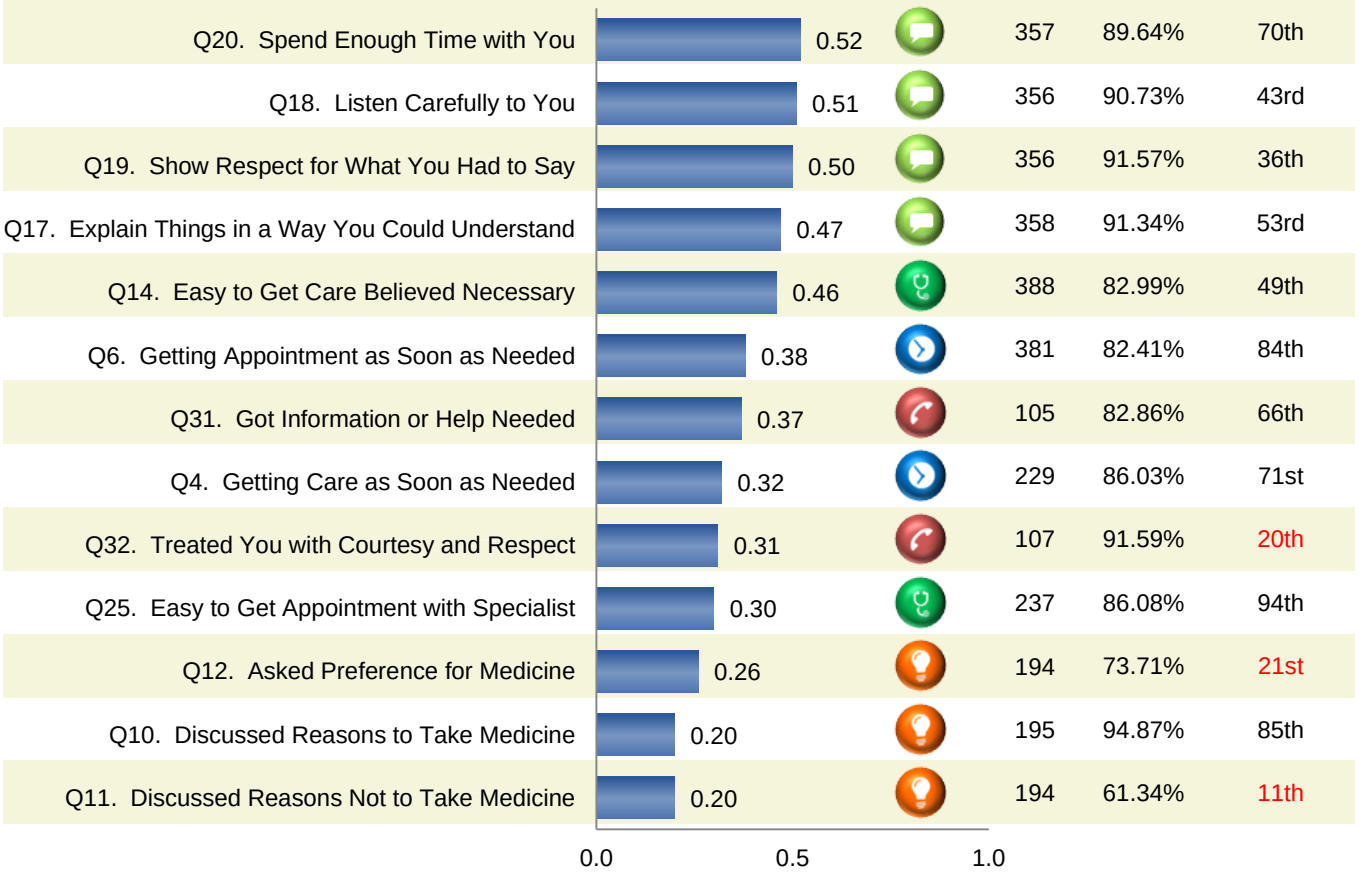
Continue to Target Efforts
(High Correlation/
Higher Quality Compass® Group)

Q20 - Spend Enough Time with You
Q4 - Getting Care as Soon as Needed

Getting Care Quickly | Shared Decision Making | How Well Doctors Communicate | Getting Needed Care | Customer Service

Executive Summary

Key Driver Analysis – Health Care



Use caution when reviewing scores with sample sizes less than 25.

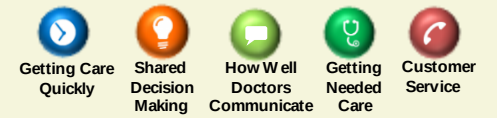
"Health Plan's Score" is the percent of respondents that answered “Always”, “Usually”; “Yes”

High Priority for Improvement
(High Correlation/
Lower Quality Compass® Group)

Q18 - Listen Carefully to You
Q19 - Show Respect for What You Had to Say
Q14 - Easy to Get Care Believed Necessary

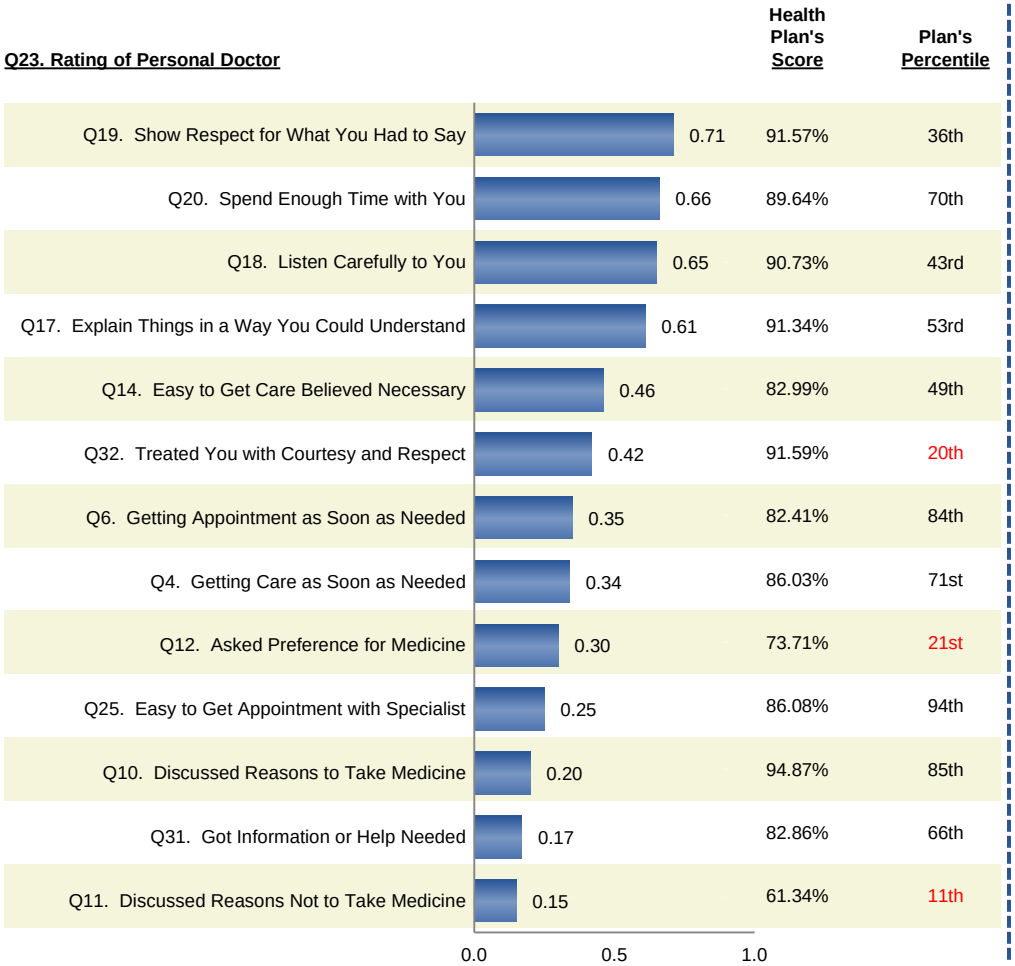
Continue to Target Efforts
(High Correlation/
Higher Quality Compass® Group)

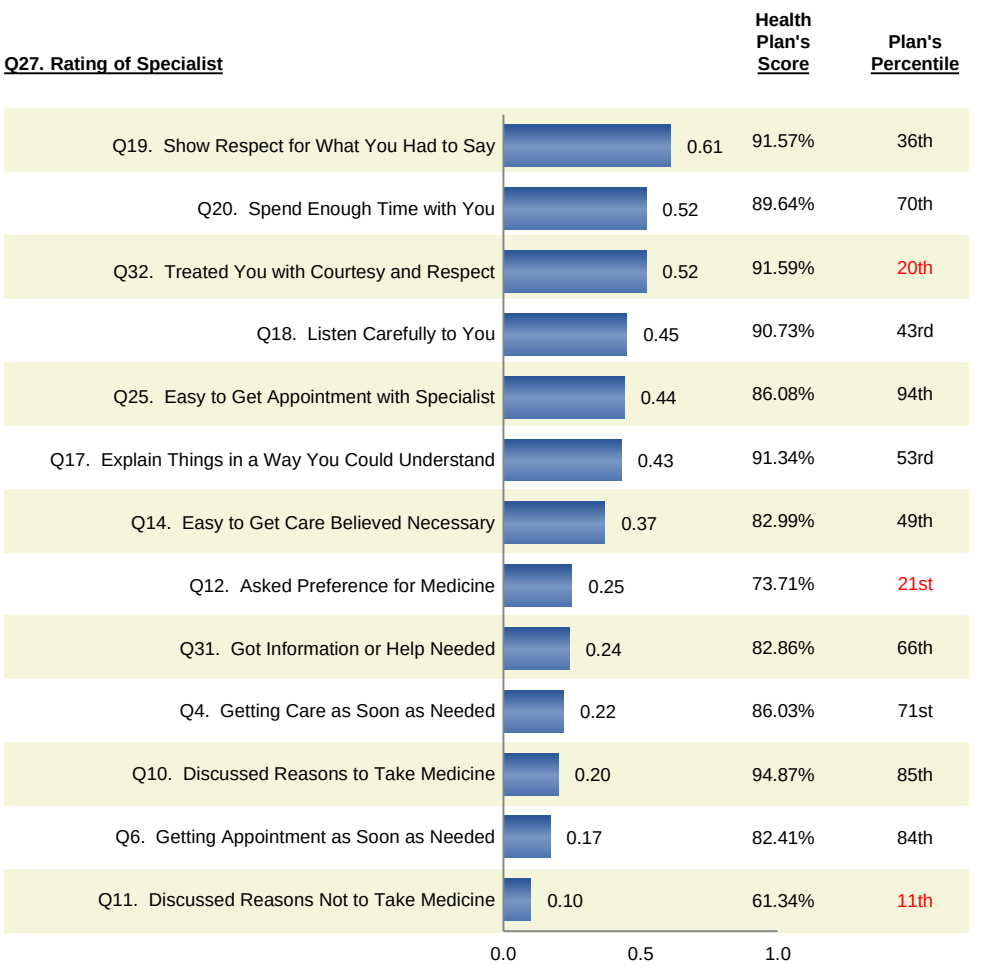
Q20 - Spend Enough Time with You
Q17 - Explain Things in a Way You Could Understand



Executive Summary

Key Driver Analysis – Doctor and Specialist





"Health Plan's Score" is the percent of respondents that answered “Always”, “Usually”; “Yes”

Executive Summary

Action Plans for Improving CAHPS® Scores

Morpace has consulted with numerous clients on ways to improve CAHPS® scores. Even though each health plan is unique and faces different challenges, many of the improvement strategies discussed on the next few pages can be applied by most plans with appropriate modifications.

In addition to the strategies suggested below, we suggest reviewing AHRQ's CAHPS® Improvement Guide, an online resource located on the Agency for Healthcare Research and Quality website at:

www.cahps.ahrq.gov/quality-improvement/index.html

Getting Needed Care

- Ease of obtaining appointment with specialist
  - Review panel of specialists to assure that there are an adequate number of specialists and that they are disbursed geographically to meet the needs of your members.
  - Conduct an Access to Care survey with either or both of 2 audiences: physician's office and/or among members.
  - Conduct a CG-CAHPS survey including specialists in the sample to identify the specialists with whom members are having a problem obtaining an appointment.
  - Include supplemental questions on the CAHPS® survey to determine whether the difficulty is in obtaining the initial consult or subsequent appointments.
  - Include a supplemental question on the CAHPS® survey to determine with which type of specialist members have difficulty making an appointment.
  - Utilize Provider Relations staff to question PCP office staff when making a regular visit to determine with which types of specialists they have the most problems scheduling appointments.
  - Develop materials to promote your specialist network and encourage the PCPs to develop new referral patterns that align with the network.

Getting Needed Care

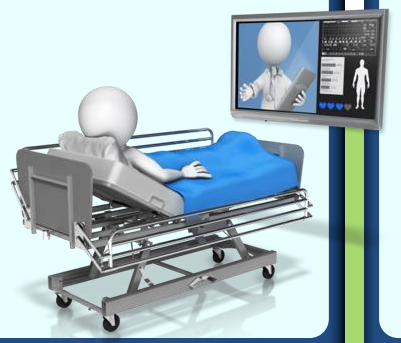
- Ease of obtaining care, tests, or treatment you needed through your health plan
  - Include a supplemental question on the CAHPS® survey to identify the type of care, test or treatment for which the member has a problem obtaining.
  - Review complaints received by Customer Service regarding inability to receive care, tests or treatments.
  - Evaluate pre-certification, authorization, and appeals processes. Of even more importance is to evaluate the manner in which the policies and procedures are delivered to the member, whether the delivery of the information is directly to the member or through their provider. Members may be hearing that they cannot receive the care, tests, or treatment, but are not hearing why.
  - When care or treatment is denied, care should be taken to ensure that the message is understood by both the provider and the member.

Executive Summary

Action Plans for Improving CAHPS® Scores (cont'd)

Getting Care Quickly

- Obtaining care for urgent care (illness, injury or condition that needed care right away) as soon as you needed
- Obtaining an appointment for routine care/check-ups
  - Conduct a CG-CAHPS survey to identify offices with scheduling issues.
  - Conduct an Access to Care Study
    - Calls to physician office - unblinded
    - Calls to physician office – blinded (Secret Shopper)
    - Calls to members with recent claims
    - Desk audit by provider relations staff
  - Develop seminars for physicians' office staff that could include telephone skills (answering, placing a person on hold, taking messages from patients, dealing with irate patients over the phone, etc.) as well as scheduling advice. Use this time to obtain feedback concerning what issues members have shared with the office staff concerning interactions with the plan.
    - These seminars could be offered early morning, lunch times or evenings so as to be convenient for the office staff. Most physicians would be appreciative of having this type of training for their staff as they do not have the time or talents to train their employees in customer service and practice management.



How Well Doctors Communicate

- Doctor explained things in a way that was easy to understand
- Doctor listened carefully
- Doctor showed respect for what member had to say
- Doctor spent enough time with member
  - Conduct a CG-CAHPS survey to identify lower performing physicians for whom improvement plans should be developed.
  - Conduct focus group of members to identify examples of behaviors identified in the questions. Video the groups to show physicians how patients characterize excellent and poor physician performance.
  - Include supplemental questions from the Item Set for Addressing Health Literacy to better identify communication issues.
  - Develop "Questions Checklists" on specific diseases to be used by members when speaking to doctors. Have these available in office waiting rooms.
  - Offer in-service programs with CMEs for physicians on improving communication with patients. This could be couched in terms of motivating patients to comply with medication regimens or to incorporate healthy life-style habits. Research has shown that such small changes as having physicians sit down instead of stand when talking with a patient leads the patient to think that the doctor has spent more time with them.
  - Provide the physicians with patient education materials, which the physician will then give to the patient. These materials could reinforce that the physician has heard the concerns of the patient or that they are interested in the well-being of the patient. The materials might also speak to a healthy habit that the physician wants the patient to adopt, thereby reinforcing the communication and increasing the chances for compliance.
  - Provide communication tips in the provider newsletters. Often, these are better accepted if presented as a testimonial from a patient.

Executive Summary

Action Plans for Improving CAHPS® Scores (cont'd)

Shared Decision Making

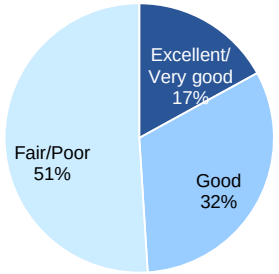
- Doctor talked about reasons you might want to take a medicine
- Doctor talked about reasons you might not want to take a medicine
- Doctor asked you what you thought was best
  - Conduct a CG-CAHPS survey and include the Shared Decision Making Composite as supplemental questions.
  - Develop patient education materials on common medicines described for your members explaining pros and cons of each medicine. Examples: asthma medications, high blood pressure medications, statins.
  - Develop audio recordings and/or videos of patient/doctor dialogues/vignettes on common medications. Distribute to provider panel via podcast or other method.

Health Plan Customer Service

- Customer service gave the information or help needed
- Customer service treated member with courtesy and respect
  - Conduct Call Center Satisfaction Survey. Implement a short IVR survey to members within days of their calling customer service to explore/assess their recent experience.
  - At the end of each Customer Service call, have your representative enter/post the reason for the call. At the end of a month, synthesize the information to discern the major reasons for a call. Have the customer service representatives and other appropriate staff discuss ways to address the reason for the majority of the calls and design interventions so that the reason for the call no longer exists.

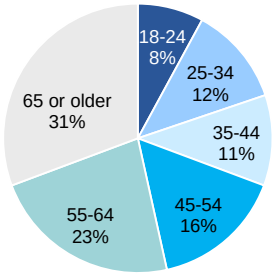
Executive Summary
Demographics

HEALTH STATUS

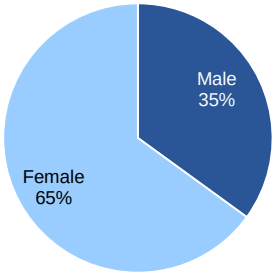


MENTAL/EMOTIONAL HEALTH STATUS

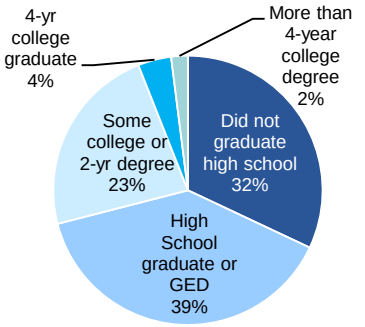
MEMBER'S AGE



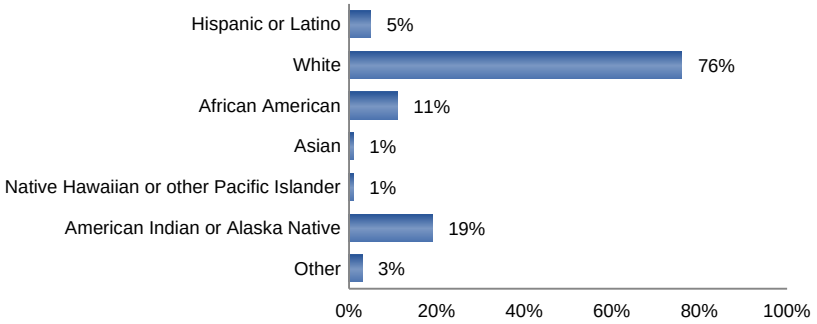
GENDER



EDUCATION



RACE / ETHNICITY



Data shown are self reported.

Executive Summary
Demographics

	2013	2014	2015	2016	2015 Quality Compass®
Q36. Health Status					
Excellent/Very good	25%	24%	20%	17%	34%
Good	27%	30%	27%	32%	33%
Fair/Poor	48%	46%	52%	51%	33%
Q37. Mental/Emotional Health Status					
Excellent/Very good	32%	35%	30%	31%	44%
Good	28%	26%	37%	30%	28%
Fair/Poor	40%	39%	33%	39%	28%
Q52. Member's Age					
18 to 24	18%	18%	7%	8%	15%
25 to 34	21%	15%	11%	12%	20%
35 to 44	15%	16%	12%	11%	17%
45 to 54	24%	25%	17%	16%	20%
55 to 64	21%	24%	23%	23%	22%
65 or older	1%	2%	30%	31%	6%
Q53. Gender					
Male	32%	32%	33%	35%	35%
Female	68%	68%	67%	65%	65%
Q54. Education					
Did not graduate high school	32%	30%	31%	32%	25%
High school graduate or GED	46%	46%	41%	39%	38%
Some college or 2-year degree	19%	20%	22%	23%	28%
4-year college graduate	2%	3%	2%	4%	6%
More than 4-year college degree	1%	1%	3%	2%	3%
Q55/56. Race/Ethnicity					
Hispanic or Latino	6%	7%	5%	5%	17%
White	74%	71%	71%	76%	53%
African American	15%	14%	13%	11%	23%
Asian	1%	1%	2%	1%	5%
Native Hawaiian or other Pacific Islander	0%	1%	0%	1%	2%
American Indian or Alaska Native	18%	18%	21%	19%	4%
Other	5%	6%	4%	3%	9%

Data shown are self reported.

Executive Summary

General Knowledge about Demographic Differences

The commentary below is based on generally recognized industry knowledge per various published sources:

Age	Older respondents tend to be more satisfied than younger respondents.
Health Status	People who rate their health status as 'Excellent' or 'Very good' tend to be more satisfied than people who rate their health status lower.
Education	More educated respondents tend to be less satisfied.
Race and ethnicity effects are independent of education and income. Lower income generally predicts lower satisfaction with coverage and care.	
Race	Whites give the highest ratings to both rating and composite questions. In general, Asian/Pacific Islanders and American Indian/Alaska Natives give the lowest ratings. Growing evidence that lower satisfaction ratings from Asian Americans are partially attributable to cultural differences in their response tendencies. Therefore, their lower scores might not reflect an accurate comparison of their experience with health care.
Ethnicity	Hispanics tend to give lower ratings than non-Hispanics. Non-English speaking Hispanics tend to give lower ratings than English-speaking Hispanics.

Note: If a health plan's population differs from Quality Compass® in any of the demographic groups, these differences could account for the plan's score when compared to Quality Compass®. For example, if a plan's population rates themselves in better health than the Quality Compass® population, this could impact a plan's score positively. Conversely, if a plan's population rates themselves in poorer health than the Quality Compass® population, the plan's scores could be negatively impacted.

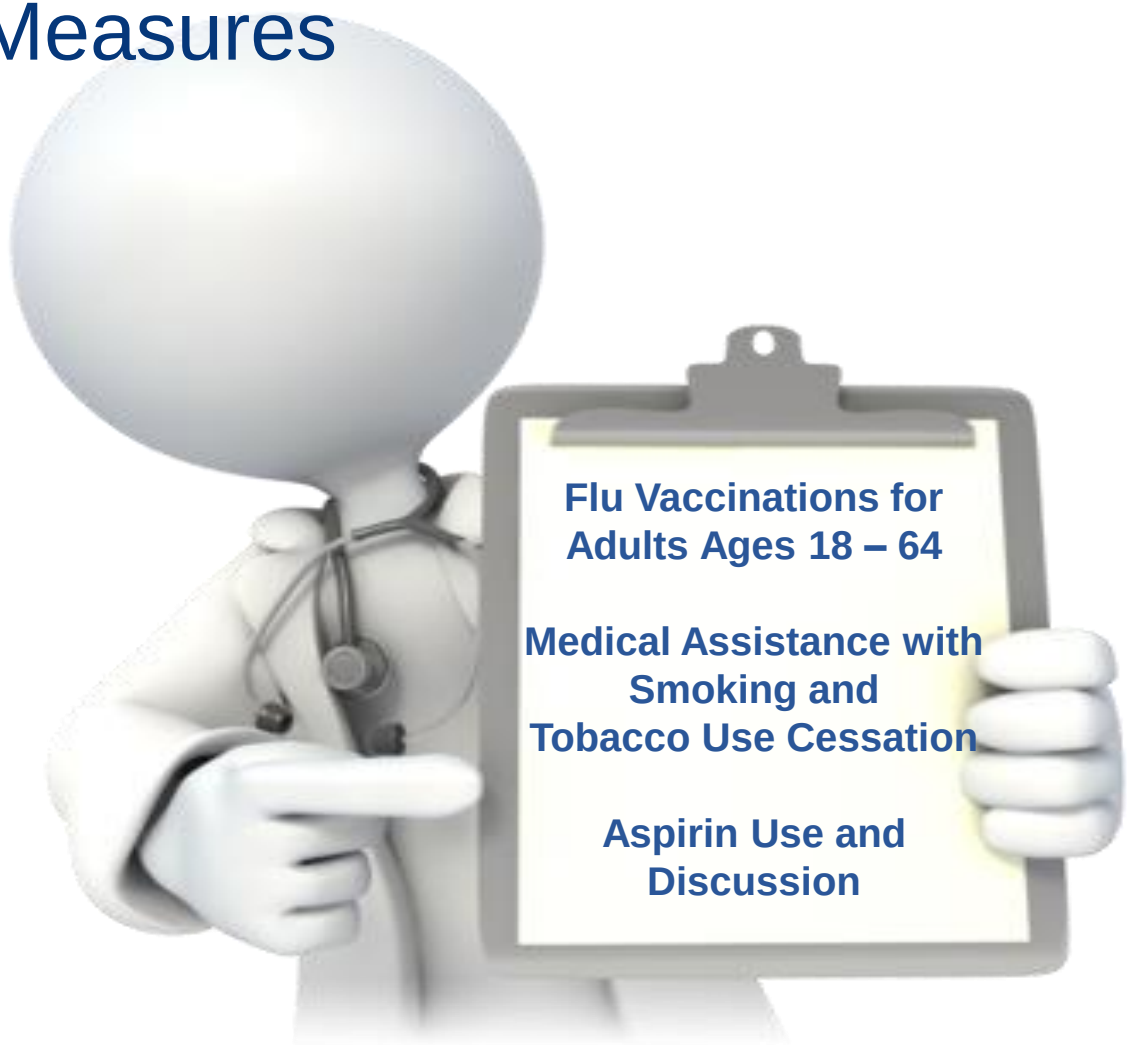
Executive Summary

Composite & Rating Scores by Demographics

Demographic	Age				Race			Ethnicity		Educational Level		Health Status		
	18-24	25-34	35-44	45+	White	African American	All other	Hispanic	Non-Hispanic	HS Grad or Less	Some College+	Excellent/ Very Good	Good	Fair/ Poor
	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Sample size	(n=36)	(n=56)	(n=51)	(n=327)	(n=360)	(n=53)	(n=114)	(n=23)	(n=427)	(n=335)	(n=131)	(n=80)	(n=149)	(n=234)
Composites *(% Always/Usually)*														
Getting Care Quickly	76	83	81	86	86	78	82	83	85	84	85	87	84	84
Shared Decision Making *(% Yes)*	80	81	81	75	76	76	78	80	76	76	79	82	73	77
How Well Doctors Communicate	93	86	92	91	92	90	90	88	91	90	92	93	92	90
Getting Needed Care	85	79	78	86	87G	79	78	77	86	83	87	91	86	82
Customer Service	63	89	81	91A	87	86	90	83	88	86	90	95	85	87
Overall Ratings *(% 8,9,10)*														
Health Care	61	66	67	77	75	67	67	78	74	74	74	87MN	73	72
Personal Doctor	78	76	79	83	83	80	78	79	82	82	81	87	81	80
Specialist	75	71	83	85	86	80	85	64	84	85	80	83	83	84
Health Plan	50	59	60	72A	68	63	64	61	68	68	66	76M	61	68

Significance is noted by UPPERCASE letters for columns significantly HIGHER at 95% confidence level

HEDIS® Measures



Flu Vaccinations for Adults Ages 18 – 64

- In 2014, the Flu Vaccinations for Adults Ages 18-64 Measure (FVA) was added to the Medicaid product line.
- The Flu Vaccinations for Adults Ages 18-64 Measure is designed to report the percent of members:
  - who are between the ages of 18-64 as of July 1st of the measurement year
  - who were continuously enrolled during the measurement year, and
  - who received an influenza vaccination or flu spray between July of the measurement year and the date on which the survey was completed
- Results for this measure are calculated using data collected during the measurement year.
- All members in the sample are asked to answer this question but only the members that meet the age criteria will be included in the results for this measure. Below are the 2016 Reported Results. See Technical Notes for Accreditation Scoring.

Q38. Have you had either a flu shot or flu spray in the nose since July 1, 2015?	2016 Reported Results*
Members that meet age criteria (results are not reportable if less than 100)	316
Members that meet age criteria and received a flu vaccination	137
Flu Vaccinations for Adults Rate	***43%***

2015 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
39.49	27.42	30.04	35.14	39.04	44.83	48.96	50.52

Plan Score: 70th Percentile

** The 2016 Reported Result is calculated using results collected during the measurement year. There must be a total of 100 or more respondents eligible for calculation in the measurement year for the rate to be reportable. This measure became eligible for public reporting in 2015.*

Medical Assistance with Smoking & Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit

- In 2010, the Medical Assistance with Smoking Cessation measure was revised and is now called the Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure. The scope of the measure was expanded to include smokeless tobacco use and revised the question response choices. This measure consists of the following components that assess different facets of providing medical assistance with smoking and tobacco use cessation:
  - Advising Smokers and Tobacco Users to Quit
  - Discussing Cessation Medications
  - Discussing Cessation Strategies
- Criteria for inclusion in this measure are members who are at least 18 years old, who were either current smokers, tobacco users, or recent quitters, who were seen by an MCO practitioner during the measurement year, and who received advice on quitting smoking/tobacco use.

Q40. Advising Smokers and Tobacco Users to Quit	2015	2016	2016 Reported Results*
Members that meet criteria (results are not reportable if less than 100)	148	160	308
Members that meet criteria and were advised to quit smoking or using tobacco	110	125	235
Advising Smokers and Tobacco Users to Quit Rate	***74%***	***78%***	***76%***

2015 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
75.79	65.20	67.57	73.60	76.74	79.41	81.91	84.18

Plan Score:
43rd Percentile

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Reported Results were calculated for the first time in 2011.*

Medical Assistance with Smoking & Tobacco Use Cessation
Discussing Cessation Medications

- Criteria for inclusion in this measure are members who are at least 18 years old, who were either current smokers, tobacco users, or recent quitters, who were seen by an MCO practitioner during the measurement year, and who discussed smoking/tobacco use cessation medications.

Q41. Discussing Cessation Medications	2015	2016	2016 Reported Results*
Members that meet criteria (results are not reportable if less than 100)	146	159	305
Members that meet criteria and discussed medications to quit smoking or using tobacco	69	82	151
Discussing Cessation Medications Rate	***47%***	***52%***	***50%***

2015 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
46.75	34.29	36.31	41.76	46.70	51.91	57.45	58.61

Plan Score:
60th Percentile

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Reported Results were calculated for the first time in 2011.*

Medical Assistance with Smoking & Tobacco Use Cessation
Discussing Cessation Strategies

- Criteria for inclusion in this measure are members who are at least 18 years old, who were either current smokers, tobacco users, or recent quitters, who were seen by an MCO practitioner during the measurement year, and who discussed smoking/tobacco use cessation medications or strategies with their doctor.

Q42. Discussing Cessation Strategies	2015	2016	2016 Reported Results*
Members that meet criteria (results are not reportable if less than 100)	149	158	307
Members that meet criteria and discussed methods & strategies to quit smoking or using tobacco	66	80	146
Discussing Cessation Strategies Rate	***44%***	***51%***	***48%***

2015 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
42.46	29.79	33.59	38.18	42.50	47.60	51.21	53.27

Plan Score: 74th Percentile

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Reported Results were calculated for the first time in 2011.*

Aspirin Use and Discussion (ASP)

- In 2010, Aspirin Use and Discussion (ASP) was added to assess different facets of managing aspirin use for the primary prevention of cardiovascular disease.
- This measure is not yet approved to be publicly reported for Adult Medicaid plans. The Aspirin results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection.
- Criteria for inclusion in the Aspirin Use measure are:
  - Women 56-79 years of age with at least two risk factors for cardiovascular disease
  - Men 46-65 years of age with at least one risk factor for cardiovascular disease
  - Men 66-79 years of age, regardless of risk factors
- Criteria for the Discussing Aspirin Risks/Benefits measure are:
  - Women 56-79 years of age
  - Men 46-79 years of age

	2015	2016	2016 Rolling Average Results*
Q43. Aspirin Use			
Members that meet criteria (results are not reportable in 2016)	44	40	84
Members that meet criteria and use aspirin for preventative measures	21	10	31
Aspirin Use Rate	***48%***	***25%***	***37%***
Q45. Discussing Aspirin Risks and Benefits			
Members that meet criteria (results are not reportable in 2016)	87	98	185
Members that meet criteria and provider discussed risks/benefits of aspirin use for preventative measures	46	40	86
Discussing Aspirin Risks and Benefits Rate	***53%***	***41%***	***46%***

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Rolling Average was calculated for the first time in 2011 and is not yet approved for public reporting.*